Alabama Medicaid Provider Enrollment

Out of State Practitioner Enrollment Application (Basic Materials)

Alabama Medicaid Provider Type/Specialty Identification Form
Alabama Medicaid Basic Provider Enrollment Information Form
Program Participation Signature Form
Alabama Medicaid Provider Participation Requirements

- The completion of this application is only applicable for out-of-state non-bordering providers (i.e., providers who are located more than 30-miles from the Alabama State line) and the clinic/facility/group/payee for that provider, who is enrolling for a particular date of service only.
- If payments are being made to any name other than the individual provider, a separate application must be completed for the group/payee.
- The date of service must be indicated on the ***Program Participation Signature Form*** supplied in this application. To be enrolled for a new date of service, after the 30-day grace period, a new application must be completed. To become a full time Alabama Medicaid Participant, the standard Alabama Medicaid Enrollment Application must be completed.
- Providers must meet the minimum requirements outlined in the ***Alabama Medicaid Provider Participation Requirements*** of this application.
- Please type or print legibly using **BLACK INK ONLY**.

ALABAMA MEDICAID PROVIDER TYPE AND SPECIALTY IDENTIFICATION FORM

Please circle the appropriate provider type (circle only one) and specialty codes (circle up to five) to ensure proper enrollment. Only the provider types listed below are permitted to enroll using this application.

PROVIDER TYPE	*SPECIALTY*
01 PHYSICIAN	03 ALLERGY/IMMUNOLOGY 05 ANESTHESIOLOGY S1 CARDIAC SURGERY 06 CARDIOVASCULAR DISEASE C9 COCHLEAR IMPLANT TEAM S2 COLON AND RECTAL SURGERY 07 DERMATOLOGY XA EENT E1 EMERGENCY MEDICINE E2 ENDOCRINOLOGY 08 FAMILY PRACTICE 10 GASTROENTEROLOGY V2 GENERAL DENTISTRY 01 GENERAL PRACTICE 02 GENERAL SURGERY 38 GERIATRICS 21 HAND SURGERY H2 HEMATOLOGY 55 INFECTIOUS DISEASES 11 INTERNAL MEDICINE M7 MAMMOGRAPHY (must submit copy of certificate) N1 NEONATOLOGY 39 NEPHROLOGY 14 NEUROLOGICAL SURGERY 13 NEUROLOGY 36 NUCLEAR MEDICINE 40 NUTRITION 16 OBSTETRICS/GYNECOLOGY XI ONCOLOGY 18 OPHTHALMOLOGY SE ORAL AND MAXILLOFACIAL SURGERY X6 ORTHOPEDIC 20 ORTHOPEDIC SURGERY X9 OTORHINOLARYNGOLOGY 22 PATHOLOGY 37 PEDIATRICS P3 PHYSICAL MEDICINE 24 PLASTIC, RECONSTRUCTIVE, COSMETIC SURGERY 28 PROCTOLOGY 26 PSYCHIATRY 29 PULMONARY DISEASE 30 RADIOLOGY R4 RHEUMATOLOGY 33 THORACIC SURGERY 34 UROLOGY S4 VASCULAR SURGERY
92 ANESTHESIOLOGY	N7 ANESTHESIOLOGY ASSISTANT C3 CERTIFIED REGISTERED NURSE ANESTHESIOLOGIST (CRNA)
08 DENTIST	V2 GENERAL DENTISTRY
79 DENTIST / ORAL SURGEON	SE ORAL & MAXILLOFACIAL SURGERY
58 INDEPENDENT NURSE PRACTITIONER (CRNP) Independent CRNPs will have a minimum of two specialties. (See Participation Requirements)	08 FAMILY PRACTICE N1 NEONATOLOGY N3 NURSE PRACTITIONER 37 PEDIATRICS
06 PHYSICIAN EMPLOYED PRACTITIONER	N3 PHYS. EMPLOYED CERT REG. NURSE PRACTITIONER (CRNP) N6 PHYS. EMPLOYED PHYSICIAN'S ASSISTANT (PA)

GENERAL INFORMATION PAGE

(1) The following information should be completed on Applicant:

Name of group/payee, if app is being completed for the payee: _____

OR

Name: (Last) _____ (First) _____ (Middle) _____

Physical Address: _____ (City) _____ (State) _____ (Zip Cd +4) _____

Mailing Address:_____ (City) _____ (State) _____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Individual SSN: _____ Medicare No (if enrolled in Alabama): _____ **V**

State License No_____ **V** License Issue Date: (Month) ___ (Day) ___ (Year) ___

DEA No.: _____ **V** DEA Expiration Date: _____ **V** CLIA No _____**V**

(Make certain to attach a legible copy of the provider's current license, DEA certification, CLIA certification and any other documents required. For assistance in understanding the enrollment requirements for each provider, please refer to the Alabama Medicaid Participation Requirements Section.)

(2) Has your license ever been limited, suspended or revoked in any state, or has your Medicare-Medicaid participation ever been limited, suspended or revoked? **Yes** ( ) **No** ( ) If yes, attach a full explanation.

(3) If enrolling as a Anesthesia Assistant, Nurse Practitioner, or Physician Assistant please complete the following sections regarding your employing physician:

Name: _____ Active Medicaid Provider Number: _____ **V**

(4) If you wish your payments made to someone other than yourself, (such as a professional group, hospital, or clinic) please complete the following information. This information will be used on your EOPs and tax statements. This information must be consistent with the payee information provided to the IRS. If payee is someone other than yourself (professional group, hospital or clinic) a group application will be required.

Payee Name (to appear on EOPs):_____ IRS Tax No: _____

Payee Address: _____ (City)_____ (State)_____ (Zip Cd +4) _____

Business Phone No: (____)_____ Fax No: (____)_____ Toll Free No: (____) _____

Contact Person:_____ Phone Number of Contact Person:_____

(5) If you have previously obtained a provider number, under the same information above, you may choose to re-certify that number.

Please indicate provider number to be re-certified here:_____

If there are any questions concerning the completion of this application, please contact our Provider Enrollment Unit. Our Toll-Free Number is 1-888-223-3630 or 334-215-0111. Return this form to EDS, Provider Enrollment, P.O. Box 244035 Montgomery, AL 36124. Please remember to retain a copy of this document in its entirety for your records.

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS AREA

Provider Number: _____

Group Number: _____

Unique I.D. Number: _____

EDS ACTION

DATE: _____ BY:_____

_____

_____

_____

SIGNATURE PAGE

Must be signed with an original signature

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to EDS and the Alabama Medicaid Agency for the purpose of issuing a Medicaid provider number.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to, medical records, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

_____

Signature

_____ _____

Title Date

Indicate date of service _____

Providers completing this application will be enrolled for only the date of service listed above, plus a 30-day grace period, with an option to re-certify other dates of service, by completing a new Out-of-State Practitioner Application.

If the service period is more than 30-days, a letter of explanation/justification must accompany this application.

If the provider would like to continuously participate in the Alabama Medicaid Program, the provider will need to complete the same application as the in-state/bordering providers.

Do Not Write In This Area

(For Office Use Only)

_____

Date**:** _____

Initials: _____

QC Date: _____

QC Initials _____

SIGNATURE PAGE (Continued)

Penalties for Falsifying information on the Medicaid Health Care Provider / Supplier Enrollment Application

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…

   A claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

ALABAMA MEDICAID PARTICIPATION REQUIREMENTS

The following chart indicates participation requirements by provider type. Refer to this chart to ensure you meet the minimum participation requirements to participate in the Alabama Medicaid Program. To serve as proof, a legible copy of the listed items must be submitted with a completed enrollment package.

Provider Type	***Participation Requirements***
Anesthesiology Assistants	• Must submit copy of Medicare Title XVIII certification letter. • Must submit copy of current license from the state in which services are provided. • Must submit copy of current certification with the Alabama Board of Medical Examiners Certificate of Registration and National Commission for Certification of Anesthesiologist Assistants. • Submit active Alabama Medicaid provider number and name of employing physician.
Certified Registered Nurse Anesthetist (CRNA)	• Must submit copy of current license from the state in which services are provided. • Must submit a copy of current certification from the American Nurses Credentialing Center.
Dental	• Must submit a copy of current license from the state in which services are provided. • Copy of DEA certificate is required if DEA number is indicated on application. • Dentists who perform anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application.
Dental/Oral Surgeon	• Must submit a copy of current license from the state in which services are provided. • Must submit copy of certification in the field or Oral Surgery. • Copy of DEA certificate is required if DEA number is indicated on application. • Dentists who perform anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application.
Independent Nurse Practitioner (CRNP)	• Must submit a copy of current Registered Nurse (RN) licensure. • Copy of current certification as a Certified Registered Nurse Practitioner (CRNP) in the appropriate area of practice (family, pediatric or neonatal) from a national certifying agency. • Neonatal CRNPs must submit a copy of the certification from the Nurse's Association of the American College of Obstetricians and Gynecologists. • Copy of the certified registered nurse practitioner protocol signed by a collaborating physician. • Submit active Medicaid provider number and name of collaborating physician. • Proof of CRNP's prescriptive authority from the licensure board, if applicable.
Physician Assistant (PA)	• Must submit copy of current license from the state in which services are provided. • Submit active Alabama Medicaid provider number and name of employing physician. • Proof of PA's prescriptive authority from the licensure board, if applicable.
Physician Employed Certified Registered Nurse Practitioner (CRNP)	• Must submit a copy of current Registered Nurse (RN) licensure. • Copy of current certification as a Certified Registered Nurse Practitioner (CRNP) in the appropriate area of practice (family, pediatric or neonatal) from a national certifying agency. • Neonatal CRNPs must submit a copy of the certification from the Nurse's Association of the American College of Obstetricians and Gynecologists. • Copy of the certified registered nurse practitioner protocol signed by a collaborating physician. • Submit active Alabama Medicaid provider number and name of employing physician. • Proof of CRNP's prescriptive authority from the licensure board, if applicable.

Provider Type	*Participation Requirements*
Physician	• Must submit copy of current license from the state in which services are provided. • EDS will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment. • Copy of CLIA certificate is required if CLIA number is indicated on application. • Copy of DEA certificate is required if DEA number is indicated on application. • Copy of Medicare certification, if Medicare number has been obtained prior to enrollment. NOTE: Not required for physician enrollment. • Copy of Mammography certificate is required if the Mammography specialty is chosen.
Clinic/Group/Institution/Payee (Relates to Section 4)	• To enroll a payee, other than yourself, a separate application must be completed and submit it with the application for the individual provider being enrolled. • Only the business related information is required. Items, such as SSN will not be required on the application for the clinic/group/institution/payee.